# COUNTY OF LOS ANGELES
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April 9, 2009

**ADOPTED**
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

48 APRIL 21, 2009

SACHI A. HAMAI
EXECUTIVE OFFICER

TO: SACHI A. HAMAI
Executive Officer
Board of Supervisors

Attention: Agenda Preparation

FROM: JOHN F. KRATTLI
Senior Assistant County Counsel

RE: **InSight Health Corporation**
**Pre-litigation Claim**

Attached is the Agenda entry for the Los Angeles County Claims Board's recommendation regarding the above-referenced matter. Also attached are the Case Summary, the Summary Corrective Action Plan and the Corrective Action Plan to be made available to the public.

It is requested that this recommendation, the Case Summary, the Summary Corrective Action Plan, and the Corrective Action Plan be placed on the Board of Supervisors' agenda.

JFK:rfm

Attachments

Board Agenda

MISCELLANEOUS COMMUNICATIONS

Los Angeles County Claims Board's recommendation: Authorize settlement of the matter entitled InSight Health Corporation - Pre-litigation Claim, in the amount of $132,283.00, and instruct the Auditor-Controller to draw a warrant to implement this settlement from the Department of Health Services' budget.

This claim seeks compensation for damages to hospital equipment owned by a County contractor.

# CASE SUMMARY

## INFORMATION ON PROPOSED SETTLEMENT OF LITIGATION

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|---|---|
| CASE NAME | InSight Health Corp. v. County of Los Angeles |
| CASE NUMBER | N/A |
| COURT | N/A |
| DATE FILED | No litigation was filed; InSight provided notice of claim on October 16, 2008. |
| COUNTY DEPARTMENT | Department of Health Services |
| PROPOSED SETTLEMENT AMOUNT | $132,283.00 |
| ATTORNEY FOR PLAINTIFF | Richard Ellingsen, Esq. |
| COUNTY COUNSEL ATTORNEY | Julia Weissman, Esq. |
| NATURE OF CASE | This is a case involving damage to an MRI scanner owned by a contractor, which occurred when a County employee who was repairing an electrical fixture tripped and activated the "manget quench" button.<br><br>Pursuant to a contract with the County, InSight operates an MRI center that is adjacent to Olive View Medical Center. On October 11, 2008, an electrical helper was repairing an electrical fixture in the ceiling, when he tripped and activated the "magnet quench" button. This caused the magnet to "quench," or to shut off immediately by transferring the magnetic field energy to the cooling agent in the MRI scanner. The quench button is meant to be used only in an emergency, because quenching the magnet typically causes severe damage to the equipment. |

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| | InSight requested reimbursement for $147,283.00, for the out-of-pocket costs it incurred for the repairs to the MRI scanner and for rental of a mobile MRI unit while the MRI scanner was out of service. The parties agreed to settle InSight's claim prior to litigation for $132,283.00. |
| PAID ATTORNEY FEES, TO DATE | N/A |
| PAID COSTS, TO DATE | N/A |

# Summary Corrective Action Plan (Revised)

| | |
|---|---|
| Date of incident/event: | 10/11/08 |
| Briefly provide a description of the incident/event: | While working to repair a broken light fixture in the Insight MRI trailer at Olive View-UCLA Medical Center, the electrician accidentally tripped as he stepped off the ladder and hit the shut-off (or Quench) button for the MRI magnet. As a result, the MRI required repairs bring the equipment back to working order. A settlement was reached between the County and Insight to share the costs associated with the required equipment repairs. |

1. Briefly describe the root cause of the claim/lawsuit:

The Facilities Division staff member accidentally tripped as he was stepping off the ladder.

2. Briefly describe recommended corrective actions:
(Include each corrective action, due date, responsible party, and any disciplinary actions if appropriate)

Reeducation of Facilities Division personnel has been provided regarding ladder safety.

3. State if the corrective actions are applicable to only your department or other County departments:
(If unsure, please contact the Chief Executive Office Risk Management Branch for assistance)

X Potentially has County-wide implications.

☐ Potentially has implications to other departments (i.e., all human services, all safety departments, or one or more other departments).

☐ Does not appear to have County-wide or other department implications.

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| Signature: (Risk Management Coordinator) Kim Kenzer | Date: 3/30/09 |
| Signature: (Department Head) Greg Polk For John Schlunhoff | Date: 3/30/09 |

CASE REVIEW SUMMARY (REVISED)

**Facility:** Olive View-UCLA Medical Center
**Patient:** N/A
**ORS #:** N/A
**PSN#:** N/A
**Date:** February 23, 2009
**Revised Date:**

**BRIEF NARRATIVE SUMMARY:**

**On October 11, 2008, an electrician from the Olive View-UCLA Medical Center's Facilities Division was working in the Insight MRI Trailer repairing a broken light fixture. When he stepped off the ladder, upon completion of the work, he tripped and hit the shut-off (or Quench) button for the MRI magnet. As a result, Insight repairs in the amount of $147,283.30 were required to bring the equipment back in working order.**

**A settlement was reached with Insight that the County would pay $132,283.30 and Insight would be responsible for $15,000 of the costs associated with the equipment repairs.**

**Was event disclosed to the patient/family? N/A**

**FACILITY INVESTIGATIVE SUMMARY:**

| Date | Investigation (including all committee reviews and conclusions for reviews) |
|---|---|
| 10/21/08 | The hospital's Risk Manager, Compliance Officer, and Facilities Division Director conducted a tour of the MRI trailer to view the trailer and the location of the Quench button and determine whether the incident could have occurred as described on the incident report. |
| 10/22/08 | The hospital's Risk Manager and Compliance Officer interviewed the Electrical Helper involved in the incident. |
| 11/3/08 | The hospital's Risk Manager and Compliance Officer interviewed the Electrician assigned to supervise the Electrical Helper performing the work. |
| | Based on the interviews conducted, it was determined that on Wednesday, 10/8/08, Insight staff placed a work order with the Facilities Division for the repair of a burned out light in the MRI procedure room. When Facilities Division staff responded they found that the problem with the light was caused by a faulty light fixture, which required replacement. Facilities Division staff indicated this to Insight |

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| | and said they could repair it that day; however the Insight staff asked that the work be performed on Saturday, 10/11/08, when it would not disrupt patients. Insight staff provided a key to the Electrical Shop staff to enter the building, but was not present on Saturday when the work was performed.<br><br>According to interviews conducted with the Electrical Helper and the supervising Electrician, the Electrical Helper followed appropriate procedure when working in the MRI procedure room, which was to remove all metal from his body, leave the tool cart outside the building, and take only one tool into the area at a time and tethering this tool to his wrist. These precautions are taking to prevent items being sucked into the MRI magnet. The Electrical Helper worked in the MRI procedure room while the supervising Electrician observed from the control room area immediately outside the MRI room.<br><br>As the Electrical Helper was stepping down from the ladder upon completion of the repair, he missed the last step of the ladder and tripped backwards, falling against the wall, bumping the cover to the Quench button with his shoulder and hitting the button itself, which turned off the MRI magnet.<br><br>The staff immediately called the Insight staff to tell them of the problem and the Insight staff indicated they would send someone over. The Facilities Division staff then locked the building and went to respond to a call from another location of the hospital. They were not contacted again by Insight about the incident. |

**FACILITY CORRECTIVE ACTIONS (SYSTEMS)**

| | **RISK MANAGEMENT ISSUES** |
|---|---|
| 1. [X ] Systems<br><br>[ ] Personnel | Failure of Insight personnel to be present to supervise work being performed in their owned/operated building. The previous contract term required the hospital to maintain the MRI trailer building; excluding the maintenance of the MRI magnet itself. The current agreement, which went into effect 7/1/08, is less clear as to the hospital's obligation for the maintenance of the existing MRI trailer. Under the current agreement, Insight is responsible for the construction and installation of a new MRI trailer/equipment and at that time, will assume total responsibility for the maintenance and upkeep of the building and equipment. |
| 2. [X] Systems<br><br>[ ] Personnel | While the appropriate procedures were followed in performing work in this area, reeducation of Facilities Division personnel regarding ladder safety is warranted. |

| Issue # | Action | Date |
|---|---|---|
| 1. | ***Systems issue*** | |
| | As a result of this incident, the hospital will no longer provide general maintenance and upkeep for the MRI trailer. Insight will be responsible for ensuring that all repairs are made to their building. | 10/11/08 |
| 2. | ***Systems issue*** | |
| | In-service education on ladder safety provided to all Facilities Division personnel. | 3/13/09 |

## FACILITY CORRECTIVE ACTIONS (PERSONNEL)

| Personnel involved in event | Status (time of event) | Current Status | Corrective Actions Taken | Date |
|---|---|---|---|---|
| No Issues Identified | | | | |